700 ASSESSMENT

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701 Overview

This chapter addresses DES/DDD's requirements for evaluation and assessment and explains the various assessment methodologies and processes used to determine or identify an individual's strengths, resources and needs. It describes formal and informal methods of assessment, including the use of such instruments as the Inventory for Client and Agency Planning (ICAP), the Pre-Admission Screening (PAS) and the Pre-Admission Screening/Annual Resident Review (PASARR). It also discusses the family/socio-medical history and referrals for additional assessments.

702 Description of the Assessment Process

Assessment is a continuing, **evolving** process rather than a discrete, one-time activity that can be initiated and completed at a single point in time. Professional assessments such as psychological evaluations and medical records are used along with the Support Coordinator's assessment, individual/family input, and a variety of specific assessment tools to develop, implement and monitor an Individual Support Plan (ISP) that addresses the individual's needs. (See Chapter 800).

The Support Coordinator's assessment should be shaped by **individual and/or family** priorities and information needs, as well as by individual characteristics and diagnostic concerns. Assessment involves several steps:

a. identifying and exchanging individual/family perspectives on the person's strengths, resources, concerns and needs;

b. identifying and exchanging professional perspectives; and

c. sharing assessment findings and interpreting their meaning.

The Support Coordinator's assessment must include frequent face-to-face, on-site interviews and observations with the person served, as well as records review. The family must also be involved for persons under

age 18, at the adult individual's request, and when a family member has been appointed legal guardian for an adult. The Support Coordinator should use holistic, interactive processes to gather the information necessary for determining an individual's eligibility for services, identifying the person's strengths, resources, and needs, and determining whether the provision of services will allow the individual to remain in his/her own home and improve or maintain his/her functional abilities. The Support Coordinator should provide the individual, and his/her family when appropriate, with an opportunity to participate in the following assessment decisions:

a. which professional disciplines will be involved;

b. who will be on the assessment team;

c. what will be the family's role on the assessment team;

d. what kinds of assessment measures will be used; and

e. when and how assessment information will be synthesized and shared.

The Support Coordinator will administer the ICAP for all individuals over the age of six (6) at intake and redetermination. For individuals who applied for services prior to the age of six (6), the ICAP will be done at redetermination. The Support Coordinator will use interview, observation, and records review techniques, including review of the PAS where applicable, to gain an accurate knowledge and understanding of the "whole person." Section 807.2 lists life domains that should be addressed in the Support Coordinator's assessment. ALTCS requires that the Support Coordinator's assessment include review and documentation of the following:

a. medical/functional status;

b. environmental needs;

c. name of the acute care physician;

d. special needs;

e. placement choices; and

f. support provided by the community/family.

The Support Coordinator's assessment begins during the intake and eligibility determination process and continues throughout the entire

period during which an individual receives services from the DES/DDD. The Support Coordinator will document this ongoing assessment in the Support Coordinator's progress notes and, when appropriate, in the ISP document(s).

The interdisciplinary team approach is an essential component of evaluating an individual's need for services. The Support Coordinator is responsible for working with the team, including the individual and family, to develop an integrated plan for the person and family that addresses service needs. (See Section 807.2)

The Support Coordinator will also assist the individual and family to identify the family and neighborhood supports such as friends, community groups, and churches which can serve as resources and community resources, such as schools and other public or private agencies, which are available to address the individual's needs.

Whenever possible, referrals should first be made to non-DES/DDD resources, however, for ALTCS eligible individuals, if non-DES/DDD resources do not provide medically necessary services in a timely manner and the situation cannot be resolved, the Support Coordinator must refer the individual to the appropriate DES/DDD staff or service provider in order to assure that quality services are actually received.

Recommendations for further assessment or evaluation will be documented in the Support Coordinator's progress notes and summarized in the ISP. Examples of the types of evaluations which may be needed include, but are not limited to:

a. psychiatric or psychological evaluations;

b. physical examination;

c. neurological examination;

d. educational evaluation;

e. occupational, speech or physical therapy;

f. recreational therapy;

g. rehabilitation or vocational evaluation;

h. adaptive behavior evaluation or direct observation of behavior; and/or

i. nutritional evaluations including specialized nutrition or dietary modifications.

Prior to the ISP meeting, the Support Coordinator will conduct a review of the case record and results of any previously completed assessments, and come to the meeting prepared to determine whether other, more formal assessments, regarding the person's medical and functional needs are indicated. Unless the person is ALTCS eligible and the needed evaluation is an ALTCS covered service, completion of the assessments identified in the ISP as necessary is contingent upon the availability of funds and prior approval by the District Program Manager/District Program Administrator (DPM/DPA) or designee.

The Support Coordinator is the direct liaison among the individual, family, community and DES/DDD. If none or only part of the identified needs can be met when the person is determined eligible for services, the Support Coordinator must continue to meet regularly with the individual/responsible person, and the family when appropriate, as specified in Chapter 1000 to:

a. assess the impact of receipt or non-receipt of services;

b. assess how the individual and family manages without support services;

c. keep the individual and family informed regarding the Support Coordinator's activities/progress toward obtaining needed services; and

d. resolve barriers to service receipt.

703 Family/Socio-Medical History

A review of a person's family/socio-medical history is helpful in planning appropriate services for the individual. By interviewing and obtaining accurate historical information, the Support Coordinator can assist the individual/responsible person to identify strengths, resources and needs, including existing support systems, issues, and concerns, which may have an impact on the person's current and future status.

Because DES/DDD services are voluntary and stress empowerment of the individual/family, the Support Coordinator must approach the interview with sensitivity and must respect the decision of the individual/family who prefers not to divulge detailed personal information. Components of an interview to develop a family/socio-medical history should include discussion of the individual's:

a. family information;

b. medical condition and history;

c. physical development;

d. cognitive development;

e. language/speech development;

f. psychosocial development;

g. self-help skills;

h. educational/vocational history; and

i. prior services received.

The Support Coordinator will document this history on the intake forms specified in Chapter 500 of this Manual, the ICAP and the Support Coordinator's progress notes.

704 Assessment Requirements for Individuals Placed in Residential Settings

Individuals residing in settings operated or financially supported by the DES/DDD, must receive certain assessments. Residential staff are responsible for obtaining documentation of the following within 30 days of admission:

a. physical examination;

b. complete medical history;

c. immunization record;

d. tuberculosis screening;

e. hepatitis B screening;

f. type of developmental disabilitiy;

g. medication history;

h. history of allergies;

l. dental history;

j. seizure history;

k. developmental history; and

l. family medical history.

In addition, the ISP team must ensure that additional evaluations and assessments are identified and obtained as described in Sections 702 and 807.2.

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705 Inventory For Client and Agency Planning (ICAP)

DES/DDD requires that the ICAP be completed by the Support Coordinator during intake and at redeterminations for individuals age six (6) and over. The Support Coordinator may not delegate responsibility for completion of this evaluation to a provider or to the family. The ICAP is protected by copyright; photocopies of the response booklet may not be used in the administration of the evaluation.

The ICAP is a standardized assessment tool which provides information regarding the individual's medical condition and diagnoses, motor skills, social and communication skills, personal living skills, community living skills, social and leisure activities, and problem behaviors, if any.

The information contained in the ICAP is to be used, in conjunction with the PAS and other assessment information, to develop functional statements of need in the ISP and to establish the necessity of the services to be provided.

The ICAP provides scores which can be used to determine the level of supervision an individual needs.

The Support Coordinator will ensure that the ICAP score for each individual is entered in ASSISTS.

706 Preadmission Screening (PAS)

The PAS is both a tool and a process used by AHCCCS to determine medical/functional eligibility for the ALTCS program.

The tool compiles demographic, functional, and medical information for each ALTCS applicant. The PAS instrument measures the level of functional and medical disability and determines if the individual is at risk of institutional placement. The PAS is administered by AHCCCS by a registered nurse and/or a social worker. Generally, responsibility for the completion of the PAS for persons served by DES/DDD is as follows:

a. ALTCS nurse/social worker teams perform the PAS for individuals who are medically involved, including **all** persons who are dependent upon a ventilator, regardless of placement; or

b. nurses or social workers, as single assessors, may perform the PAS for individual who reside in an ICF/MR, group home, developmental home or any HCBS setting, who are not medically fragile or dependent upon a ventilator.

The PAS assessors have an ALTCS physician consultant available for physician review should there be a question of medical eligibility. The ALTCS eligibility process must be completed within a 45 day period for most applicants. Requests for ALTCS medical eligibility determinations for individuals in acute care facilities are handled on a priority basis upon receipt of the request by the Bureau of Medical Eligibility Regional Manager.

AHCCCS readministers the PAS to determine if the individual remains eligible for ALTCS. If the individual is determined ALTCS eligible, a copy of the PAS evaluation is available to be printed from the ALTCS automated system called CATS.

The ISP Team must use the PAS, along with the ICAP and other assessment information, to develop the ISP and substantiate the need for the services to be provided. Although AHCCCS uses the PAS, in part, to determine whether DES/DDD has identified appropriate services to meet the person's needs, service recommendations recorded on the PAS are not binding. The PAS is simply one component of the assessment process.

707 Preadmission Screening/Annual Resident Review (PASARR)

The Omnibus Budget Reconciliation Acts of 1987 and 1990 (OBRA '87 and '90) mandate that a nursing facility (NF) funded by Medicare or Medicaid **must not** admit, after **January 1, 1989,** any new resident with mental illness (MI), cognitive disability (MR) or a related condition, unless the State's mental health or cognitive disability authority has determined that, because of the person's physical or mental condition, the person requires the level of care/services provided by a NF.

This federal legislation requires a Preadmission Screening and Annual Resident Review (PASARR) to assess and determine the need for services provided in a NF and the need for specialized services. The legislation applies to all individuals with MI, MR or related conditions, without regard to the method of payment for their care, whether by private pay, Medicare or Medicaid. AHCCCS, as the State Medicaid agency, has responsibility for oversight of PASARR.

PASARR has two levels of screening and review. Level I involves the identification of individuals currently residing in, or seeking admission to, NFs who are suspected of having MI, MR or related conditions and who need to undergo further screening through Level II. The Level I screening is done by the NF staff or the ALTCS PAS teams.

Level II is the process by which the Department of Health Services (DHS) or DES/DDD makes determinations as to whether the individual actually requires the level of services provided by a NF and whether the individual requires specialized services. If there is a possible diagnosis of MR or a related condition, the PASARR Coordinator from DES/DDD Central Office does a Level II evaluation. Subsequent evaluations are required whenever there is a significant change in the physical or mental condition of the individual. DHS is required to screen persons with MI. For individuals with dual diagnoses of mental illness and cognitive disability or a related condition both agencies will perform the screening.

Upon completion of the PASARR, findings are forwarded to the PCP, AHCCCS, the NF, the individual/responsible party, the Support Coordinator and to the DPM/DPA. Findings must indicate recommendations for specialized services. "Specialized services" are usually outside the scope of a nursing facility, and are more intense than those normally provided by the NF, such as active treatment and

therapies. If specialized services are recommended, DES/DDD must provide them or arrange for the provision of additional services to raise the level of intensity of services to the levels needed by the resident.

If a move to a less restrictive setting is recommended for the individual, the Support Coordinator must insure the ISP team process is followed, including participation by the individual/responsible person, PCP, NF staff, District discharge planning team and other relevant individuals.